

FILED FEB 11 1942

Registration District No.

Primary Registration District No. 4018

Registrar's No.

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Ladsonia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Home
In this community 68 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES HENRY JENKINS

3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sarah Jenkins 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased May 20 1857 (Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 27 If less than one day hr. min.

9. Birthplace Illinois (State or foreign country)

10. Usual occupation Retired Merchant

11. Industry or business Restaurant business

12. Name Daniel Jenkins

13. Birthplace Virginia (State or foreign country)

14. Maiden name Clenor Davis (State or foreign country)

15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Sarah Jenkins

(b) Address Ladsonia Mo

17. (a) burial (b) Date thereof Jan 18 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Ladsonia Mo

18. (a) Signature of funeral director H. S. Stranger

(b) Address Ladsonia Mo

19. (a) 1-17-42 (Date received local registrar) (b) J. W. Watkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Audrain
(c) City or town Ladsonia (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16 year 1942 hour 2 minute 4 M.

21. I hereby certify that I attended the deceased from

Jan. 2 1942 to Jan 16 1942

that I last saw him alive on Jan 16 1942

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 2 wks

Due to Arteriosclerosis

Due to advanced age

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94

Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work? (e) Means of injury

23. Signature R. B. Baize (M. D. or other) DO

Address Ladsonia Date signed 1-16-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.